COBRA STATEMENT OF CURRENT COVERAGE
To be completed by Agency Payroll Personnel

Name _____ **SABHRS ID**_____

Address_____ **SSN#**_____

_____ **Coverage Current As Of (MM/YY)** _____

Termination Date:_____

Instructions: Agency payroll personnel will write down the employee's current coverage, as shown in SABHRS, as of the first day of the pay period in which the employee terminates. **This form is only used for terminating employees who are eligible for continuation of benefits under COBRA and wish to prepay premiums.** The terminating employee will use this form to make coverage decisions on the COBRA Election Form, below.

You are currently enrolled in the _____ Medical Plan	Change my medical plan to: ☐ Traditional ☐ Managed Care - PEAK Health Plan ☐ Managed Care - Blue Cross/Blue Shield ☐ Managed Care - New West Health Srvcs	**If electing a Managed Care plan, be sure to check the service area and complete the Primary Care Physician section below.**

**********MEMBERS ELIGIBLE FOR CONTINUATION OF COVERAGE**********

Type* of Coverage	Name	Rel**	Birthdate	SSN	First and Last Name of PCP	City

*Type: M = Medical; D = Dental; V=Vision **Relationship: Sp = Spouse; DP = Domestic Partner; D = Daughter; S = Son; X = Disabled

COBRA ELECTION FORM
To be completed by terminating employee

If you are terminating from state employment, and you are eligible to continue coverage through COBRA, you may continue your insurance coverage by self-paying the full cost of your premiums – see the COBRA rate sheet.

Please read through the "Notice of COBRA Rights" which provides information on your options **before** making your elections**.** If you pre-pay premiums for your elections, you will not get a refund if your coverage changes before your pre-payment runs out. Elections made on this form cannot be changed until the next Annual Change Period, effective the first day of the next year.

INSTRUCTIONS: 1) Have your payroll clerk complete your "Statement of Current Coverage" (above). 2) On the Statement, Circle the names of dependents you will continue to cover after termination, and the type of coverage to be continued (Medical, Dental, or both). 3) Check the box next to the Medical Plan you wish to elect (above), if changing your current election. 4) Check your method of premium payment (below). 5) Sign and date this form and return to State Personnel, address below.

METHOD OF PAYMENT:
____ Monthly Self-Payment to State Personnel by check; or
____ Electronic Premium Deduction from Checking or Savings (Attach Authorization Form). (If you are pre-paying some months of coverage, your preferred method of payment will begin when the pre-payment period ends.)

I hereby elect to continue the coverage selected above with the State of Montana Employee Group Benefits Plan. This coverage will remain in effect unless I change my coverage election, my dependents lose eligibility or I fail to pay the required premiums by the due date. I understand that premiums may be adjusted for any future increases or decreases in the cost of the coverage(s) I have selected.

Signature_____**Phone:** _____
Date:_____

STATE PERSONNEL USE ONLY
Cobra Coverage effective: _____ **Total Payment Due:** _____ **Authorized by:** _____

Distribution: Return the completed white copy to the State Personnel Division, 125 N Roberts Room 125 Mitchell Building, PO Box 200127, Helena, MT 59620-0127. The yellow copy is for the agency and the pink copy is for the employee. If you have any questions, call us at 1-800-287-8266 or 444-7462 if in Helena, or e-mail us at BenefitsQuestions@mt.gov

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